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17820 SE 109th Ave #102 Summerfield, FL 34491 (352) 347-3338

1800 SE 17th St #601 Ocala, FL 34471 (352) 351-0375

Email: [contact@liveoakfootankle.com](mailto:contact@liveoakfootankle.com)

Website: [www.liveoakfootankle.com](http://www.liveoakfootankle.com/)

**Insurance Authorization**

I authorize my physician to release any medical or other information needed to insure payment of insurance benefits on my behalf.

I understand that I will be responsible for any deductible or co-payments not paid by my insurance.

A copy of this authorization may be used in place of the original.

I assign the benefits payable for physician services to the physician furnishing the services.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_